Quality Measures Workgroup: Population Health Task Force
Draft Transcript
October 13, 2010

Presentation

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Welcome, everyone, to the last group call that we're going to have. I think we're making good progress. I think today we're going to get a little into the weeds a bit on these measures, but I think we're in a good place measure-wise. I think the first two domains— I'd like to go over those, see if we can map those out semi-quickly, although I think, based on some feedback, that we do have a little work to do on those. Still waiting from SAMHSA for you guys' measures for the alcohol and depression, but I think we can hit the blood pressure, glucose for the preventive services and the tobacco and obesity for the healthy lifestyle. Then, everyone's favorite topic health equity, how we're going to solve that.

So just to reiterate, today's our last meeting. I'm not sure how this works, but it looks like I have a meeting with— Lanre, is that with you to finalize the report or—?

Lanre Akintujoye – ONC
Yes, it is with me. After this meeting, we're going to finalize the report and then send it out to the group so that they can kind of review it. Then that will be it for the Tiger Team.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Today's really our last chance. We'll push forward today. I think we'll be able to get through everything. Three hours is a long time, so hopefully we won't need all of it, just from a mental health perspective. Any questions or any comments from anyone before we dive in? Is this an okay process for folks?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
SAMHSA, just an update: IHS and SAMHSA have discussed measure definitions and we could do of some verbal presentation now. We're planning to send it in during the call.

Lanre Akintujoye – ONC
Just really quickly from me, I guess I'm in a conference room that needs to be used by somebody else so I might have to disconnect and then reconnect.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
If folks are good with that, we can hit the healthy lifestyle behaviors first. Tobacco: I'm going to try to stop us from getting too far in the weeds. I think some of this can be left to the measure developers. I, unfortunately, am also a measure developer, and so the pain of that is not unknown, but I think we get the concept down. We specify as much as we can. Thanks, Fran, for sending your comments. I think we definitely should discuss a lot of those issues over patients moving back and forth in the same year. Did we use the calendar? Beginning and end of the calendar year as a cut-off or how we can do that. I think we can work that out.

Theresa Cullen – Indian Health Service – CIO
Jesse, I guess my question, though, was even more basic. Do we even need to work that out now? Or is the assumption that the measure will get accepted and then the details will be worked out?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I would love if we can do that. Lanre, any preference either way? Did you already get kicked out of your conference room?

Lanre Akintujoye – ONC
Did you just ask a question? I had to leave to find another station.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Based on the e-mail I sent in Terry's response around not keeping the group in the weeds too much, we were wondering how far do we have to specify this if we have to talk. Can we just present the measure concepts as quick rate with maybe, at most, with a reporting period of a year or measurement period of a year? Or do we have to say, "A patient who moved from current smoker to former and not back and was seen at least two times before—" Or status beginning January of the calendar year and status being at the end of the calendar year? Do you have to get that in depth?

Lanre Akintujoye – ONC
I think as kind of in depth as possible. Maybe that might be too much, but kind of specifying a numerator and denominator and general specifications might be good.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay. I think that's doable.

Lanre Akintujoye – ONC
Otherwise, yes, we don't want to get too bogged down by the nitty gritty.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. This eventually will go to the HIT Policy and then whatever's approved will go to—who, the measure developers?

Lanre Akintujoye – ONC
Yes.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
We have to leave them some work to do. So let's, I guess, jump into it. If we can start with tobacco: The measure that was proposed was basically quick rate, which was patients mo— So the denominator was number of patients with a smoking status of current smoker within the past year. The numerator was number of patients in the denominator with the most recent smoking status of former smoker. Are we good with this as is or any comments on this one?

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
That seems reasonable. That seems like a reasonable place to at least start the conversation, in terms of moving it on to the next level.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
If everyone else is good with this, we'll— Lanre, is this enough specificity for you?

Lanre Akintujoye – ONC
I'm definitely not the measure expert. I think that generally it is good, but I think if you guys have anything more specific to add, that would definitely be welcome.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Maybe we'll come back to this, but for now, we'll let it stand. Obesity: The proposed measure— A bunch of these are going to be packages, I think, just from— They have different strata, so in order to get the combinations, we may have to do multiple measures.

Numerator for obesity: Number of patients in the denominator with the most recent BMI overweight or normal weight. The denominator's the number of patients with a BMI of obese within the past year. Then the next one was the number of patients with a BMI of overweight within the past year, and the numerator are those patients in the denominator who moved to normal weight.

Theresa Cullen – Indian Health Service – CIO

I think it's a great measure, but you can see my comments. I think all of us have struggled with this as primary care providers. I'm wondering if it's even reasonable to assume that we can move somebody from obese to normal weight in a year.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
What about—? I guess it depends. Even obese to overweight would probably be—

Theresa Cullen – Indian Health Service – CIO
Well, if your BMIs 45, you're moving to 29, you're going to have a problem. I mean, I think the issue, Jesse, is are we trying to see if the health IT system can do it, which obviously, it should be able to measure this? Or do we want to do reasonable goal setting?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. I think it's also sending a message— It's kind of do we put something that may be easier to achieve or do we—? It's a bit of a fine line, I think.

Theresa Cullen – Indian Health Service – CIO
Well, if we're doing that, I think it's probably reasonable. I mean, we could probably get patients from overweight to normal weight, because overweight is less than 30 and normal weight's 25. But the problem with obese—

Jesse Singer – DHMH of New York City – Exec. Dir. Development
There's no top limit.

Theresa Cullen – Indian Health Service – CIO
There's no top limit. So, I don't know.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Maybe we could just do a straight percentage. Patients who are obese who've lost 10% of their—

Theresa Cullen – Indian Health Service – CIO
Body weight.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Body weight.

Theresa Cullen – Indian Health Service – CIO
Now, that's a good one.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
For patients who are overweight and move to normal weight? Or do we just straight say— I don't think we should just straight say 10% across overweight and obese, but—

Theresa Cullen – Indian Health Service – CIO
Maybe we just do one of them.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes.

Theresa Cullen – Indian Health Service – CIO
I think, actually, it's probably more important for the—

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Obese?

Theresa Cullen – Indian Health Service – CIO

Well, no. What I was going to say for the health IT system itself to be able to calculate the percentage in decrease because if you share that information to the patient, it's positive. It's self-activating. "Here's your char—" Kind of like we do with hemoglobin A1C, "Look, your chart's going down. Here's where you hit your 10% mark."

Jesse Singer – DHMH of New York City – Exec. Dir. Development
So you're thinking that the straight 10% off—?

Theresa Cullen – Indian Health Service – CIO
I don't know. I like that idea with obesity, at least, because I think it's a goal that many patients might be willing to set for themselves.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
We've got two measures, I think, in obesity. The one with denominator of the patients obese, the numerator there is number of patients in the denominator with the most recent BMI of overweight, normal weight, or 10% loss of body weight in the past year. For the other one, number of patients with BMI of overweight denominator, the numerator is they move to normal weight. Is that too many things in the numerator?

Theresa Cullen – Indian Health Service – CIO
Not electronically. It's whether—

Jesse Singer – DHMH of New York City – Exec. Dir. Development
No, EMR-wise, we're—

Theresa Cullen – Indian Health Service – CIO
Yes. We're fine.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
We're fine. I like the structure of them both. The strata are known: there's overweight, there's obese, there's normal weight. Moving from one strata to the next, I think there's going to be a principle that we're going to be putting forward for all these measures, but I do want to make it— Someone's got a BMI of 40. To move to overweight in a year, probably isn't super healthy. I'm just trying to maintain the structure but accommodate—

Theresa Cullen – Indian Health Service – CIO
I'm fine with the ad that's and/or 10% weight loss or—

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Any thoughts from other folks? I think we have a majority rule. For obesity, we've got two measures in that. This is just for the folks taking notes. So the first measure is denominator: Number of patients with BMI of obese within the past year. The numerator is the number of patients in the denominator with a most recent BMI of overweight, normal weight, or a 10% weight loss. That's it.

Then the second measure of the obesity section is the denominator is number of patients with a BMI of overweight within the past year. The numerator is number of patients in the denominator with most recent BMI of normal weight.

With no objections, I think we're good on that measure. Alcohol.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
The measure description would be percentage of patients aged 18 and older for alcohol screening 18 and older who were screened at least once in the past 12 months for unhealthy alcohol use. Jacobs uses that unhealthy alcohol use that we know IHS uses hazardous alcohol use and the VA uses alcohol misuse, but unhealthy is something that is probably more equivalent to risky and something the NIAAA would endorse. Then it would be with the validated alcohol screening instrument.

The numerator would be the number of active clinical patients aged 18 and older who were screened in the past year for unhealthy alcohol use with a validated alcohol screening instrument. The denominator would be the total number of active clinical patients age 18 and older. We give examples of validated tools, including the audit or the .... These have been identified by the U.S. Preventive Services Task Force.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
So denominator here is total patients over the age of 18 who came in for a visit?

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Right.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Then the numerator is out of those patients in the denominator, how many were screened at least once for unhealthy alcohol use with a validated alcohol screening instrument.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Right.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
The point of the time frame of all patients seen in a visit in the last year is something we discussed with IHS. IHS uses active clinical patients because there's a variety of issues as to how often someone should be screened and whether an active patient may not come in but once every 18 months. There'd need to be some work on measure ... on the language definition, but that as to whether it was only those who had come in for a visit in the last year. VA uses the last two years. There's a lot of variation on that, so we used active clinical patients without a timeframe.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
My only concern with—as far as the ambulatory docs—what active— What's the definition of active clinical patient? Would we say those are patients that were seen within the past two years?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Actually, IHS has a separate definition for that they've used in their system.

Theresa Cullen – Indian Health Service – CIO
Yes. Well, you know, this is a real gotcha Jesse, in this whole meaningful use thing. In fact, at the same time we're having this call, there's this dialogue with CMS about defining who's a patient for the denominator. It's not been defined. We used two visits in the last three years. VA uses a different thing. HEDIS uses continuous enrollment in the last 18 months. The MU measures from CMS have not come out with a real definition other than right now they're telling me it's anybody that got seen in a 90 day period.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Oh, wow.

Theresa Cullen – Indian Health Service – CIO
Well, this is for 2011 because it's 90 days. They're saying it's now, I'm saying— This is from CMS. We limit the initial patients as the denominator only those seen by the EP during the reporting period. The reality is that CMS is going to have to make this decision, I guess.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay. So, we'll say active clinical patients by whatever definition—

Theresa Cullen – Indian Health Service – CIO
Yes. CMS comes up with.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. Exactly.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Alcohol brief intervention will be the next measure. This would be the percentage of patients age 18 and older who screen positive for unhealthy alcohol use and received a brief alcohol intervention. The numerator would be the number of active clinical patients age 18 and older who screened positive for unhealthy alcohol use and received brief intervention. The denominator would be the total number of active clinical patients 18 and older.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Actually it should be who screened positive—

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Who screened—

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Excuse me. Yes.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
So the denominator is total number of active patients who screened positive?

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Who screened positive. Yes.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Yes.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Yes. Good point. Oops.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Then the numerator, sorry, was?

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Number of active clinical patients 18 and older who screened positive for unhealthy alcohol use and received brief alcohol intervention.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
So the numerator's receiving the intervention?

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Right. Under this because this is a brief intervention, as opposed to the former one.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
What is this?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
E-mail this as soon as we finish the discussion here.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay. The only issue with having two measures is the same that we'll run into, which we may with all the others where we're splitting them out into the strata because they may only allow one, but I think we'll just—

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Cross that bridge.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. Exactly. I'd ... out it forth and have them say no.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Exactly.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Is everyone good with the alcohol measures? Anyone not good with it? Then we'll go to effective preventive services. That was the blood pressure. I've talked with our cardiovascular docs here. The issue with this is we get into a number of strata. So, we've got JNC-7, stage two, stage one. There's pre-hypertension then there's normal tensive. In speaking with our cardiovascular folks, she was advising me to— The stage two to stage one were good. Stage one, I think what we want to do is instead of having stage one to pre-hypertension, we want to just say stage one to control. So we don't have four strata: normal, pre-hypertensive, stage one, and stage two.

The measure that we're looking at are— The first one would be denominator is number of patients with BP classification of stage two within the past year. The numerator would be number of patients in the denominator with the most recent JNC-7 classification of stage one or control. Stage one is 150 to 159 over 90 to 99 and then control would just be less than that—less than 140.

Then the next measure would be, denominator: number of patients with a BP classification of stage one within the past year. The numerator would be number of patients in the denominator with the most recent classification of control. Those would be the two.

Theresa Cullen – Indian Health Service – CIO
Jesse, does this assume then that—?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Patients don't move the other way?

Theresa Cullen – Indian Health Service – CIO
No. What I was more worried about is that it's really a continuum. So, you're going to take the first blood pressure of that patient in a year, and that's going to be the baseline.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think it's basically like the oldest measurement within the measurement period. I think to do kind of measure developer speak.

Theresa Cullen – Indian Health Service – CIO
Yes. Just because the odds are that person's going to get stage two, stage one, free, and then control.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. I think I mentioned it somewhere that we may get patients counted twice as they move down. That was one of the—

Theresa Cullen – Indian Health Service – CIO
Oh, wait, but you don't want that.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. I don't think— Well, I mean, I—

Theresa Cullen – Indian Health Service – CIO
No.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I forget which measure— I put it in the BMI measure as a comment. I said patients could be counted twice if they're obese and moving to overweight, and then moving from overweight to normal. But then your measure upstream of that should be decreasing its denominator. I'm not sure it's a terrible thing. It could ... exclusion.

Theresa Cullen – Indian Health Service – CIO
It seems like each person should get counted once, from the most remote measurement to whatever is the most current measurement. I will tell you we never use one single BP reading for anything.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
No, I know. We don't either. It's always an issue.

Theresa Cullen – Indian Health Service – CIO
It's a huge issue and you're going to have primaries freaking out.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Let's say this is a measurement period of a year, and we measure the oldest and the most recent. There's only one measurement. This quality measure's only run once, let's say on December 31. What we look at is the oldest and the newest so it's one snapshot. So you miss that transition if they move past the transition. Otherwise, you're okay.

Theresa Cullen – Indian Health Service – CIO
Otherwise they just had a fight and their blood pressure's off the wall today. I really agree with this measure. I think it's really important, but I'm the family medicine doc and CMS is going to change my reimbursement based on this and you only gave me one chance.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Do you want to do a mean?

Theresa Cullen – Indian Health Service – CIO
I don't know. That's what we do because ….

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Oh, really?

Theresa Cullen – Indian Health Service – CIO
Well, yes, especially because you have a systolic and diastolic control, so you have all these variables. I think what we should do is propose it and then— Because we don't have to work out the details here, right?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Right.

Theresa Cullen – Indian Health Service – CIO
And see what happens.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I mean, I kind of feel like we shoot for the stars and then—because things are only going to— As with the rest of meaningful use, people will complain and thresholds will get lowered. I'd rather start at that top. Kind of set the goal and let folks nickel and dime it down.

Theresa Cullen – Indian Health Service – CIO
But I do think we should say the patients only get counted once. Don't you think? I think that's going to be crazy if we let them get counted more than once. I don't see how they would counted more than once

anyway because if there's only the beginning blood pressure most remote, there's only one value. Then there's only one value at the end.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Right. If it's just a single snapshot—

Theresa Cullen – Indian Health Service – CIO
Yes.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
If you're not measuring it over time. If I'm only measuring you December 31st and I say, "Give me your most recent," that's not going to change. We shouldn't be catching— Each person gets one shot on goal with this. I think we're okay if we word it that way. Any thoughts on this from anyone?

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
I agree with the snapshot should only allow them to be counted once, but I'm wondering whether what Terry's asking is whether we should say that things, in this case, should be counted once as opposed to leaving it open and not really addressed. Is that what I'm hearing correctly, Terry?

Theresa Cullen – Indian Health Service – CIO
Yes. That is.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think if we word the measure right, it basically makes it impossible for them to be counted more than once.

Theresa Cullen – Indian Health Service – CIO
Right because there's only one beginning point.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, and one end. Well, I'll make sure when we write the measure that it leaves no room for error. That's a good point. So everyone's good with control stage one, stage two?

Theresa Cullen – Indian Health Service – CIO
Jesse, can I talk about one other thing really quickly, then? I think that the way I'm approaching these measures is that in 2013, CMS is not going to be rewarding results or incentivizing results. That once again, in 2013, this is just actually getting the health IT system and the providers to pay attention to these things. It would be helpful—if other people agree with that—that we pose that as assumption.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Meaning reporting only?

Theresa Cullen – Indian Health Service – CIO
Well, I'm worried that if you go out and you're going to say to the doc, "You've got to do all these things. Oh by the way, if you don't meet the blood pressure goal—" because in MU, there's no goals for 11. It's just you've got to report, so there's no disincentive. I think we have to be cautious of the primaries.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
So, we're not setting thresholds, which I think is good.

Theresa Cullen – Indian Health Service – CIO
Yes. Okay. That's what I really wanted to clarify.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay. Yes, I think that's fine.

Theresa Cullen – Indian Health Service – CIO
Then we're not saying the goal is 50%.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think the only thing that we specified a goal on, which was still very drafty, were the health equity, meaning between disparities.

Theresa Cullen – Indian Health Service – CIO
But we can specify goals as long as there's not reimbursement issues tied to the goals.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Well, I think if you mean we'll come out of the bottle at some point, and I'm not sure. I mean, we can do thresholds, but then I think we know what will happen. It doesn't mean that even if we don't propose thresholds that someone else won't, but I mean, in terms of thresholds, we would just make them arbitrary, and I'm not sure how we can— If we said 80% or 40%, I don't know which is right. So, I'd be okay with no thresholds but if you want to think about thresholds, then … talking about it. Do you want us to?

Theresa Cullen – Indian Health Service – CIO
No, I don't. I think to put a new measure out there that hasn't been validated and tested and then to set a threshold is an onerous assumption.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, I agree. So I think we keep thresholds off the table for these. When we get to health equity, we can talk about that, but I think that's a different idea anyway. Health equity piece is, basically, if you're providing bad care, then you should be providing bad care for everyone. So ... what we want.

So I think we're agreed. No thresholds in this stage. We're good on the blood pressure. Anything else on blood pressure before we move to glucose control?

Glucose: We've got a couple options here. So there's the measures that I drafted were, the denominator was number of patients with an A1c greater than 9 in the past year. The numerator are patients in the denominator with a most recent A1c of less than 7 to 8.9, which I guess is all less than 9. The second piece of that was the denominator of that was number of patients with an A1c of 7 to 8.9 within the past year. The numerator was number of patients in the denominator with the most recent A1c of less than 7.

I guess there's a couple of alternatives. One would be denominator of A1c greater than 9, numerator would be moving them to less than 7, or we just do kind of a binary greater than 9 to less than 9. So there's a few things to play with here.

I guess the first piece is do we break A1c up into three strata, meaning less than 7, 7 to 9, and greater than 9? Or do we just do greater than 9 to less than 9? Or, as Terry— I think in one e-mail, it's not this one, but you were saying an improvement of 1% or something? ... kind of thing.

Theresa Cullen – Indian Health Service – CIO
Yes. That's because of all the struggles we've had with providers not wanting—when they get close to 7, the data. I mean, they've just been reluctant to push understandably.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, for sure. So would that mean you're leaning more towards moving patients greater than 9 to less than 9?

Theresa Cullen – Indian Health Service – CIO
I think getting anybody less than 9 would not be controversial.

Jesse Singer – DHMH of New York City – Exec. Dir. Development

But moving them beyond 7--

Theresa Cullen – Indian Health Service – CIO
I think gets a little—

Jesse Singer – DHMH of New York City – Exec. Dir. Development
What do folks think about those choices?

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
It seems to me that that's a reasonable compromise given the situation and again, these things will be challenged or ratified subsequently, so—

Jesse Singer – DHMH of New York City – Exec. Dir. Development
So I guess in light of that, the other side of that is, since they will be challenged, should we be aggressive and let it get whittled down? Or do we kind of just provide this—I wouldn't say more reasonable, but maybe more reasonable measure, greater than 9 to less than 9? Or do we put forth and say we do want to measure greater than 9, to 7 to 9, to 7, and then folks can challenge that if they want? That's what I would tend to go with, but—

Theresa Cullen – Indian Health Service – CIO
But the problem is we don't want to be in a situation where people are going to question the science. I think that that's what you're saying right now. I think that that's what Kelly was saying. So pushing below 7, you may have a lot of docs that say, "You don't know what you're talking about. Blah, blah, blah." Now, you're right. We could leave it to whoever's going to vet these measures after us, but I think that science is really unclear right now about whether to go below 7. So to move from above 9 to below 9 is really clear. To move from 9 to 8 or 7 to 8.9 is probably reasonable too. I think this last one may just get us in trouble.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Although these are just completely arbitrary and we would just be inventing it, so I'm not sure that this is the idea. But would we want to say 7 to 8, 8 to 9, 9 and above?

Theresa Cullen – Indian Health Service – CIO
I think what we should do is, for somebody like the ADA, those aren't arbitrary. Maybe what we should say is move from poor to good to excellent control. Whoever defined those, put the numbers in here and we'll sign off on it. What do you think about that? Because I'm just worried we're going to get in that debate, you know. ADA and AHA don't agree and who wants to be in the middle. There's smarter people than at least me who could figure that out. I mean, I think we could put these numbers in, Jesse, but just say they're a marker for poor control and good control.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay. I like that better. I just worry if we just have the words. So I'll stipulate that these are just a marker.

Theresa Cullen – Indian Health Service – CIO
Yes, but we think it's above 9.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Right. So we'll put that together. When we put the report together, and send it to the group. If there's any thoughts—if it doesn't come across the way we want—we can change it then. See what folks think.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Alright. Compromise idea. It's a good idea.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Alright. Okay. So that's glucose. Depression?

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
We've got two components since we're being adventurous here. One, for adults, the other for adolescents. I'll mention the adults first. The measure description: Percentage of patients aged 18 years and older who are screened at least once during the past 12 months for depression using a validated screening instrument. The numerator would be the number of active clinical patients aged 18 and older who were screened at least once during the past year for depression using a validated screening instrument. The denominator would be the number of active clinical patients aged 18 and older.

A similar approach would be the second measure, which is depression screening for adolescents. The difference would be aged 12 to 17. It's a ….

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Should we just say greater than 12?

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Well, adolescents are treated separately and are generally seen separately. Why don't we go for the two measures and see if other people want to collapse the two?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay. The only reason I say that is because that's what they did with smoking.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Well, that's a possibility, greater than 12 or 12 and older.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. So they did smoking that same way, greater than 13 or something.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Alright. Well, that meets our needs. They use different instruments, I mean, they're using the validated instruments in the patient health questionnaire too from PHQ-2. Why don't we do that?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay. So greater than and equal to 12. Right?

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Yes.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Twelve and older.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
So that sounds good. There's a list, I guess there's the PHQ and—

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Yes. PHQ-2 and PHQ-9.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Those are the two referenced in the Preventive Services Taskforce. They do refer to a whole host of instruments, but they highlight those two so we've done the same.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay. I'm good with those. Anyone not good with it? So, we're two down, just health equity to go.

Health equity: What we had talked about on the last call was looking at healthcare disparities. What populations are a concern in terms of disparities in healthcare and using the first two sub-domains—so the measures within healthy lifestyle and clinical preventive services—and comparing those rates across the disparity demographics, and saying— It's basically, there should be no more than a something, X% discrepancy of these rates between these healthcare disparity populations. We said we would do one measure for the healthy lifestyle, one measure for effective preventive services, and then the third measure's kind of up in the air still. We had put forth as a proposed measure, number of patients moving from an uninsured to insured status, but—

So if folks do want to— I'm fine with all three of these measures. I like the ideas. The attention to the fact that we want to be looking at these measures across all populations for healthcare disparities and I think using a whole sub-domain to do that is important, especially with the population of public health sub-group. We all deal with vulnerable populations, so I think having a third of our measures be dedicated to this is definitely worthwhile.

What do folks think about this? If people agree to do these first two measures at least this way, then we have to start looking at what populations we want to stratify across. I looked a little bit at this this morning, so I have some thoughts. But I guess the first piece is to get down are folks okay with going forward with this concept for this sub-domain? I'm hoping people are talking but they're just on mute.

Theresa Cullen – Indian Health Service – CIO
I wasn't on mute, but I think it's good.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay. It's complex, so I just wanted to make sure. It's kind of a new type of measure.

Theresa Cullen – Indian Health Service – CIO
Yes. You know, it is—

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Which is fine, you know? I think it'd be great if we could innovate some new measure concepts here.

Lanre Akintujoye – ONC
Just as a quick note, we will be collecting methodological issues as we kind of explore some of these new measure types, so we will be keeping that and keeping notes about the gaps also.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Does anyone object to doing these first two measures in the sub-domain this way?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
We suggest you go ahead with them in the way that they've been framed.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay. So that's great. What we have to talk about is what are the disparity populations we want to put forth here. I was looking at some research, just a little earlier today. I was looking at this ARC report, which I could send. It's from 2003. I'm not sure that populations have changed much since then, but they may have. But this is an ARC report on national healthcare disparities from 2003. I'll send that out to you guys. Basically what they were talking about what race, ethnicity, income, education, place of residence, and they do mention insurance status in that report. There are six pieces here. Is anything obviously missing or are people good with these?

Theresa Cullen – Indian Health Service – CIO
Yes. I think we should follow what ARC has traditionally been measuring.

Jesse Singer – DHMH of New York City – Exec. Dir. Development

Yes, and I thought it was a good place to start. So, people are good with these: race, ethnicity, income, education, insurance status. Place of residence, I wasn't— That was kind of the only thing that stood out to me as something. Education could be asked as a structured data point. Place of residence? I mean, you'll know. I'm not sure what that would mean and how the analysis would be done nationally. I wasn't sure if that was a viable data point in terms of something that's EHR-able. I don't know if folks have experience with that. I just don't know how we would get at that in terms of analysis.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Is this something ARC has done?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I don't know. I didn't have the chance to—

Theresa Cullen – Indian Health Service – CIO
I wonder if it's by zip code or something? I don't know. I think unless it's pretty clear that it's a clear data field that people are collecting in patient registration, it might be difficult.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
They just issued their 2010 report too. I've got it in my office. I could take a look to make sure they've kept the same parameters.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Oh, that's great. A disparities report?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Yes.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Awesome. If you could. You don't have that electronic, by any chance?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
I might. It may be, actually, on ARCs Website.

Theresa Cullen – Indian Health Service – CIO
Yes. I'm pretty sure it is on their Website.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I'm here. I don't—

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
You're on the Website?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. Oh, wait. Here's 2009.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Yes, it was 2009. There you go.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay.

Theresa Cullen – Indian Health Service – CIO
Jesse, maybe what we should do— I, in fact, had printed this out for myself for 2009 so I have it, but they look at— To approach this a little more academically, not that I'm very academic. But how they divvied up quality of healthcare effectiveness, access to healthcare, priority population. Maybe what we should try to

do is make sure we're getting— We can at least crosswalk to something here, which I think we can based on what we've already proposed.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think we can.

Theresa Cullen – Indian Health Service – CIO
Yes, but that would be good because you want to reference stuff so you could reference this.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. I'll take a look through this one.

Theresa Cullen – Indian Health Service – CIO
See, right, because effectiveness percentage of patients with a disease or a condition to get recommended care, so we'd be looking at that, but it certainly— What's the cut? Is the cut race, which we have or maybe we have them all.?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I got it from the end of the report last time.

Theresa Cullen – Indian Health Service – CIO
You mean in the priority population stuff?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. Also at the end, they had said there's a gap here and it would be great to be able to fill it around the collection of this data in terms of quality.

Theresa Cullen – Indian Health Service – CIO
Then I think what Aneel said was really true, and I don't know how to do that. That one comment he made about—

Jesse Singer – DHMH of New York City – Exec. Dir. Development
....

Theresa Cullen – Indian Health Service – CIO
Yes, if you're only seeing insured patients. What do we do with those guys?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, I don't know.

Theresa Cullen – Indian Health Service – CIO
Well, the nice thing about, you know what if we do this is because education's one of them even though we didn't propose it is that then people will at least be collecting educational—

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. That's what I was thinking as a structured element that's currently ....

Theresa Cullen – Indian Health Service – CIO
Yes. It looks just—it's like high school or not high school.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I'll look through this. I don't know if people want to look through it now, and make sure it's still ... with the 2003.

Theresa Cullen – Indian Health Service – CIO

Yes. It looks like for, at least where you live, it's really trying to get at rural. That seems to be the cut on it. Residents of rural in America, which would make the White House happy and everybody happy if we did a cut on that. I think that you can do that by zip code but I don't know for sure.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I see rural areas. There's also women, children, and the elderly.

Theresa Cullen – Indian Health Service – CIO
Yes. I'd be in favor of including rural versus urban or whatever it's versus just because I think the rural docs are— Our partners are always saying how hard it is.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I mean there's a language issue here too.

Theresa Cullen – Indian Health Service – CIO
Right.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
So, race, ethnicity, English proficiency, but I'm not sure—income—

Theresa Cullen – Indian Health Service – CIO
Yes. I just think it makes sense for us to follow this report because then we're supporting ARC, we're supporting— This is a legislated report that has no end, so you know it will happen and we'll be able to defend what we're proposing.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, I agree. So there's eight here? So we've got race, ethnicity, recent immigrant, limited English proficient, low income, women, children, older adults, residents of rural area, and individuals with disabilities and special healthcare needs. Education is not on here anymore.

Theresa Cullen – Indian Health Service – CIO
Oh, you're right.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Let me see if maybe it's under barriers of healthcare, if we can swing it because I think it's important. Oh, yes. Here— There's also insurance, race, ethnicity, family income, education, residence location. I think we could probably squeeze in insurance status and education because they do some of their analysis using that, in terms of access. It's defensible. It's just not laid out as one of their priority populations. Or we can just say amongst priority populations as determined by ARC.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
I think we should make specific reference, otherwise ARC probably has done other things and ... kind of open-ended.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, I'm just trying to be lazy. So they do a lot of their cuts by age, race, ethnicity, income, insurance, residence location, education. I mean, although it's not called out as a priority population, it is called out in components of healthcare access.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Right, under access.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. Health insurance. I don't think people would look at us funny if we did.

Theresa Cullen – Indian Health Service – CIO

No, I don't think so either.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Would people be okay with those? Race, ethnicity, English proficiency, income, women, children, older adults, rural, people with disabilities, education level, and insurance. That's ten.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Yes.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
It's reasonable.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
They get to suggest whatever else they want .... We need to be able to quantify these things, and that's the other thing. We need variables that people are going to use. If it gets too elaborate, it's meaningless construct.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I personally think ten is a lot, but I wouldn't be up for cutting any of these. I think we're okay with putting it forth, and letting folks cut it if they want. Is everyone okay with these ten?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Yes.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Yes.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Then I guess the issue is across the other two sub-domains. So for healthy lifestyle ..., you say— The question is what are we quantifying here? Are we measuring the number of domains where the disparities exceed 10% of the non-priority population numbers or, you know, less than 10%? Quantifying this just a little— I'm sure we can solve it. It's just something we have to figure out.

Theresa Cullen – Indian Health Service – CIO
Is 10% based on anything or just what we think?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Oh, no. I was just putting ... placeholder.

Theresa Cullen – Indian Health Service – CIO
Yes. Because I think that's the right way to approach it, that the difference is greater than some number. From a health IT perspective, you're already going to have all this other stuff programmed. All you're doing is putting a different denominator in, so you should be able to get the report.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Are we measuring the number of domains where there is disparity greater than a certain percentage or are we measuring across all of these, the percentage where—?

Theresa Cullen – Indian Health Service – CIO
Well, if we want to make it helpful to the provider, it seems like they need to have to granular data. So they need to be able to say, "Oh, look. My—" I know we're just doing our low domains, but let's say we were doing Pap smears. "Okay. Look, my Pap smear rate's the same, but my mammogram rate's really different."

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Different for those of low income?

Theresa Cullen – Indian Health Service – CIO
Yes. So I should— Kind of the example you gave last time. Right? Isn't that what you said? That is was really low and so you were going to change how your outreach was?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. So I guess do we—? I mean, I don't want to make— The difficulty here is we've got ten strata.

Theresa Cullen – Indian Health Service – CIO
Yes and we have all these other measures, theoretically.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
We've got six measures, so we're looking at 60 measures, if we do it that way.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
That has become complicated.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes.

Theresa Cullen – Indian Health Service – CIO
Yes. Way too complicated.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. I think we can get by with putting 2 or 3 measures in a ..., but I don't think we can get by with putting 30 measures in a ....

Theresa Cullen – Indian Health Service – CIO
Yes.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
That's the only reason, if we want to— That was the only reason I— I'm not saying this is the way to go at all, but just in terms of the operationalizing of this measure is something we need to work out, just because it's complex. Out of these ten areas— I mean, you do want the granular data. You do want to know where your disparities are.

Lanre Akintujoye – ONC
I was thinking, maybe in the same way that you guys kind of identified your sub-domain areas based on the major causes of all-cause mortality, you might want to look at some of these disparity areas and kind of identify what you think are kind of most indicative of health disparities and indicative of causing the greatest mortality, if that's helpful.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
….

Jesse Singer – DHMH of New York City – Exec. Dir. Development
So even if we narrowed it down to, let's say, three, what's the— I guess the issue I'm having trouble with is how do we construct this so that we get a—? What's the aggregation of this across the other two sub-domains and across these strata that gives us—? Even if it's three, we're still looking at nine measures per …. Basically, what I'm concerned with is if we can get the construct down, then we can adjust either the number or—

Theresa Cullen – Indian Health Service – CIO
So, Jesse, are you trying to ask which—like smoking, obesity, alcohol screening—we think we should measure on these?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
No. I was assuming we'd do all of them, from the sub-domains. I was trying to think— Let's just take the first measure in health equity. For the sub-domain healthy lifestyle behaviors, how do we apply these ten strata to those three measures in a way that we're measuring something meaningful in terms of disparity and shining a light on disparities in healthcare without creating 30 measures from the 3—1 for each strata?

Theresa Cullen – Indian Health Service – CIO
I don't know how you can compress these, at least, though.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I mean, even if we compress these to 5, we're still looking at 15 measures. I'm not if that's necessarily the way to go.

Theresa Cullen – Indian Health Service – CIO
Well, what you could do is just pick one of the healthy lifestyle behaviors. Then condense these to five and then you'd have five measures. I don't know what's the most important, though. I think producing something that has 30 numbers will just be ignored.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I know. It would. I don't think they would let it go through in the first place.

Theresa Cullen – Indian Health Service – CIO
No.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
But we thought extended income for proxy measure for some of the other—

Theresa Cullen – Indian Health Service – CIO
Yes. That's a good point.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
I think income is approximated for quite a bit. I mean, given the limitations that we're addressing, it … people's choices. The only thing it doesn't actually capture is some of the cultural variables, but we're not capturing that anyway. So what we're basically capturing from a number of other studies is income.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
We've got these ten strata. What if the measure was how many of these strata displayed a greater than 10% disparity and that was the docs number. So it was like an out of ten. So it was a zero to ten, lower number is better. For tobacco, if they showed a large disparity race, ethnicity, English proficiency, and income, but the other seven showed no disparity, then— Or their score could be seven, how many didn't show a disparity? It could be a seven—

Theresa Cullen – Indian Health Service – CIO
So they'd get a score and they could drill into it if they wanted to.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, but all we have to specify is this aggregation. So for each of the measures in each sub-domain, they would get a number out of ten or it could be a percent, honestly. If they got seven out of ten with no disparities, they're 70%. If they're ten out of ten, no disparities greater than whatever percentage that we decide on, then they're 100% and that's their measure. It's kind of an aggregate of an aggregate. Or is that kind of wacky?

Theresa Cullen – Indian Health Service – CIO
No, I think that that's a good thing.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I like it.

Theresa Cullen – Indian Health Service – CIO
Well, because it will only give them one number. They won't be overwhelmed. If it's bad, hopefully they'll pay attention. I mean, if it's ten out of ten bad disparity, then you know they're really in trouble.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Right and you're talking population level across the country.

Theresa Cullen – Indian Health Service – CIO
Yes.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
What do folks think about that? I think that gave me a headache. Any objections to that?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
No ....

Jesse Singer – DHMH of New York City – Exec. Dir. Development
It's kind of like we develop this thing here called the super score. This is an aggregate of how you're doing on utilization and quality from the data that we get. We grade all the practices so we know who needs the most help, kind of like that. When you're looking at a large volumes, I think it's really helpful to stratify. I like it. If no one objects, I think—

Theresa Cullen – Indian Health Service – CIO
No, I think it's a good place to start, Jesse. It's comprehensive. It's consistent with ARC. We didn't pick stuff out of a hat. It's a number. It's one result that can be drilled into.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay. Awesome. Threshold-wise, do we want to—?

Theresa Cullen – Indian Health Service – CIO
No.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay. Do we want to say X% and let that be determined by others smarter than us?

Theresa Cullen – Indian Health Service – CIO
I think it's a hard one because actually the X% should be zero. Know what I mean?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, that's true, actually.

Theresa Cullen – Indian Health Service – CIO
We don't want to say that any disparity is acceptable.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Fair enough. So we've got those two. Then the last one— What do people think about this, uninsured to insured? I feel like it's a little too simple. I don't know. Not simple, but I'm not sure if I thought this through well enough or—

Theresa Cullen – Indian Health Service – CIO
I think it's simple but it's really important.

Jesse Singer – DHMH of New York City – Exec. Dir. Development

So we would say patient in the denominator with an insurance ... status of uninsured at the beginning of the reporting period. We use the same construct. Their oldest insurance status within the reporting period compared to their newest status at the end. What Aneel was saying— I don't think I followed this totally. If they got low scores, probably need all patients in the denominator.

Theresa Cullen – Indian Health Service – CIO
Well, because his worry was what if you only took care of insured people.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, and one uninsured.

Theresa Cullen – Indian Health Service – CIO
Yes. So it would look like you got 100%.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. So he was saying put every patient in the denominator with the delta from uninsured to insured minus insured to uninsured.

Theresa Cullen – Indian Health Service – CIO
Okay, it's getting too complicated for me.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, I don't—

Theresa Cullen – Indian Health Service – CIO
But I think ... point's well taken is that you don't want to hurt people who took care of a lot of uninsured.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
So, I 'm not sure. Do we specify a minimum denominator? I would not like to do that, saying only where uninsured meets 10% of your total population or something? I don't know. I'm sure what he's saying is right, I just don't understand what the—

Theresa Cullen – Indian Health Service – CIO
The math part.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, the math. I don't understand the math.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Why is the person reporting this—the healthcare organization—have any responsibility on—? Is it we assume that they are trying to move people into insured categories? Is that the improvement expectation?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, I think they should.

Theresa Cullen – Indian Health Service – CIO
Yes. I do too.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
The question is can they?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
So, just looking at some of our FQHCs, they've got a whole slop of people just dedicated to getting patients on Medicaid. When they show up with nothing, the first thing they do is get their paperwork

going, get them into care, into insurance status. That's an FQHC, so they granted— Oddly they have more resources than us in private practice, but I think this is a good aspiration.

I think if docs really do want to be medical homes, they should be— I don't know. I think it's such an indicator of disparity that I think they— I don't know. I mean, the docs will probably, I imagine, would balk a little bit and say, "I'm a doctor. I'm not a whatever," but I don't know. I kind of like this idea. I think it makes people aware.

People who aren't in public health don't really think about these kind of things. A lot of the education we've had to do here with our docs, running this project is showing them their data in the population view, which isn't something they're used to seeing. I think it's eye opening if you say, "You've got this many patients who are uninsured and you didn't really do anything. Here's some phone numbers to give them, at least, or something." You've got a patient with poor English proficiency, low income, and they're uninsured, I think—

I say we float it and see, but I think it's a good goal. I just don't know how to account for the low denominator. Maybe we don't have to specify that?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
What about the practice that has none that are uninsured? They simply don't. They're not—

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. Their denominator would be zero.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
What does that mean? They don't really apply? This measure does not apply to them?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
So if you set a bar that you take only insured patients, you don't have this one apply to you.

Theresa Cullen – Indian Health Service – CIO
Yes. See, that's what Aneel was saying.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
You don't want to encourage cherry picking, I guess.

Theresa Cullen – Indian Health Service – CIO
Right. I don't know what we'd do with that one.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
We don't want to penalize—

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Well, we know that there are providers who only take cash or insurance—

Theresa Cullen – Indian Health Service – CIO
Right or the boutique practices.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Right, and otherwise, bye.

Theresa Cullen – Indian Health Service – CIO
Right.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Are there other data sources that are going to be picked to get this data? Like within a state, how many have gone from uninsured to insured?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Usually just for the EHR.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
I know, but I'm just curious whether we're getting … people of—yes.

Theresa Cullen – Indian Health Service – CIO
No, I think you're right. I think healthcare reform, in fact, at the department level, has proposed this as a measurement for the states.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Right.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
So should we—?

Theresa Cullen – Indian Health Service – CIO
Right, so the issue is does that mean we shouldn't deal with it?

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
No, we should deal with it, but the caveat is there is a … as it were for certain types of providers. Now, 100% insurance can also be a red flag, oddly enough. It doesn't mean you're doing something wrong. In fact, you may have a very aggressive insurance enrollment program going on, which might account for why you're 100% insured, but it's certainly just as much of an indicator that something either good or bad is happening. ... 20% uninsured is T1 and that changes to 15% uninsured at T2.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Good point. I don't know. I kind of liked this. I mean, I imagine with healthcare reform, this is going to be huge, but I don't know. Do folks want to take it out, keep it in? I kind of like it.

Theresa Cullen – Indian Health Service – CIO
I'd keep it in.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Keep it in.

Theresa Cullen – Indian Health Service – CIO
It doesn't hurt us.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
It's also … it's really important, too.

Theresa Cullen – Indian Health Service – CIO
They're going to just tell you you're crazy, Jesse, not us.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I know that—

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
We'll blame it on Jesse. … do it.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Maybe they can work out the issues with ... take care of the people who can opt out of the—

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Right. Maybe there'll be a menu. Okay. So we've got these. Lanre, what else do we have to do?

Lanre Akintujoye – ONC
… kind of, they wanted us to briefly think about some of the methodologic issues related to the measures we've developed and to try to do a kind of gap analysis on the domain areas that we've established.

Theresa Cullen – Indian Health Service – CIO
They wanted us all to do that in the next hour and a half?

Lanre Akintujoye – ONC
I guess you can think of this, maybe, as the kind of menu set of the meeting. Just whatever we can— Just broadly. We don't have to delve that specifically, but broadly just think about these issues. Also, just for me, for the conversation on the health disparities, did we identify numerator and denominator? I just wasn't sure.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. Well, we didn't do it officially, but I was going to write it up. The way I was thinking of it was—and I'd probably need like a good hour to kind of formulate this, but it's going to be basically— Of all of those measures, when you cross tabbed against all these areas of disparity, what percentage were there disparities across these ten? I just articulated that really badly, but—

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Yes.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
The idea being of these ten areas across the sub-domains, how many of these areas did stay disparity? We aggregate all the areas that did or didn't display disparity. That's the measure result. So if they displayed disparity on three areas, that means 70% of the time, they're treating their patients equally. And 70% is the number.

Lanre Akintujoye – ONC
Okay. Then, just to clarify again for the uninsured/insured measure, I was just wondering what was the kind of final word on that measure?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think at the time as it stands, the only— So at one methodological issue that we can write down is that— So the denominator is number of patients with insurance status of uninsured within the past year. That would probably be with insurance status of uninsured as their oldest status in the reporting period. The numerator would be number of patients in the denominator with most recent insurance status of insured.

The methodologic issue is for institutions with very small denominators of uninsured patients, how do we measure that without—? If they convert one patient from uninsured to insured and that's their only uninsured patient. They're at 100%. So one methodologic issue is how to address that.

I think some other methodologic issues are what Terry was bringing forth in the e-mail around do we use calendar year. What about patients that move back and forth? Making sure we only count patients once as they move through the continuum, which I think we solved with the way we were going to write the measure, but I think those are the methodologic issues.

Some other issues are around the A1c. Clinically, not wanting to push patients below 7 on their A1c. How do we measure without encouraging that? I think, just off the top, those are some methodologic issues and gaps.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
I know that NQF speaks a lot about composite measures. I guess one question or methodologic question would be is there a way of developing better composite measure approaches to the screening preventive measures?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
For our set, or just in general you mean?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Single screening, integrated screening, …, I know, alcohol, tobacco, and drugs have done some of that with certain instruments that simplify and allow one set of data to give you some feedback. So it's a methodologic issue, I think that's under the parsimony rule. That's something that might be of interest over time.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Because you're a … care type of measure?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Possibly. Yes.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
That's some good stuff, Lanre?

Lanre Akintujoye – ONC
Yes. Very good.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Alright. I'm going to try to write all this stuff up, I guess.

Lanre Akintujoye – ONC
Before we end, we do need to make sure we leave the time open for public comment.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay. Does everyone feel like we satisfied—?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Before we do that, can we just, on the issue of gaps, is the reason to raise the discussion for screening for HIV/AIDS, for example, which is a major public health issue? I know we had talked about domestic violence. Again, these are ones that are gaps. They need to be addressed over time, but when we talk gaps, what was the intent when you said we could give some recommendations about gaps?

Lanre Akintujoye – ONC
The recommendation for gaps, I think, is going to another Tiger Team that is focused specifically on methodologic issues. I think these gaps analyses are just for our report so that we kind of clearly state that we identified these areas, so these are all the areas that we think are important, but we weren't able to get to them.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Well, and I would be interested, if there are some other areas that the group thinks important.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I'd actually like a say preventable hospitalization. That's something that we've been doing a lot of work on here. I just don't think there's room enough, and I'm not sure, exactly, if that falls into our Tiger Team, but I think being able to track and measure rates of preventable hospitalization. So, you have a patient who has asthma who's not on a long-acting corticosteroid, you just have them on albuterol rescue. They

show up at the ER, miss school, parents have to miss work, which possibly could have been solved with treatment in the outpatient. If we can put that forth as a gap that is really important that needs to be addressed. I think that will play into the accountable organization piece as well.

Lanre Akintujoye – ONC
Okay.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Anyone feel like we did good on this stuff? Anything that we feel like we didn't address? Kind of speak now—

Theresa Cullen – Indian Health Service – CIO
Well, the violence issue is huge in the communities where I work, and I know we talked about intimate partner violence, but—

Jesse Singer – DHMH of New York City – Exec. Dir. Development
You want to submit that as a gap?

Theresa Cullen – Indian Health Service – CIO
Yes. I think it's a gap. You get into that whole argument: Is it within the purview of the healthcare system and who's supposed to do what, but— Or you could just put intentional and unintentional injury. It's kind of that whole thing that we haven't gotten at, which is responsible for huge decreases in life expectancy. So it's interesting because we're concentrating on mortality, but we're not looking at years of preventable life lost, YPLL, which some would argue is probably more important a focus.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Well, consistent with that is the issue of HIV.

Theresa Cullen – Indian Health Service – CIO
Right.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
An older term morbidity in both situations in terms of diminished health.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
And healthcare system costs a ton.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
There was one thing I forgot to mention. I apologize. On the BP measures, I was thinking about adding instead of just straight hypertension, also to break out the one for diabetes and end stage renal, greater than 130/80 or less than 130/80. I apologize for bringing this up when we're almost done. Any thoughts or feelings one way or the other on that?

Theresa Cullen – Indian Health Service – CIO
You mean for the diabetics?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes.

Theresa Cullen – Indian Health Service – CIO
Yes, my thought is that ADA and AHA should get it together.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I know.

Theresa Cullen – Indian Health Service – CIO

I'm sorry.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
No, it's okay.

Theresa Cullen – Indian Health Service – CIO
I think it's an important issue.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
How about this? Do you think if we specify that as a measure it would prompt … on it?

Theresa Cullen – Indian Health Service – CIO
No. That's a good …. Maybe it will, Jesse.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I hear it all the time from the docs, too. Any thoughts from breaking that out in the same way we did hypertension?

Theresa Cullen – Indian Health Service – CIO
I think you have to break it out. That's the problem.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I mean, it's such an obvious thing. I'll put that in and folks can comment on it in the report. It'll just follow the same exact construct. Instead of having three strata though, it will just be greater than 130/80 and less than.

Theresa Cullen – Indian Health Service – CIO
Yes.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Anything else from anyone? Okay. I guess we can do public comment.

Operator
No comments at this time.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Well, thanks, everyone. I don't know. I thought this was a great group, so I think we got a lot done.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Thank you for being coordinator and we did get a lot done.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, I think so.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
So, thank you.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Thanks, everyone.

Theresa Cullen – Indian Health Service – CIO
Yes, thanks, everybody.

Ahmed Calvo – DHHS/HRSA – Acting Deputy Director, Center for Quality
Thank you, everybody.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Alright.

Lanre Akintujoye – ONC
Thank you all very much.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Thanks, all.